VOL. 15, NO. 4 NOV.-DEC., 1965

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

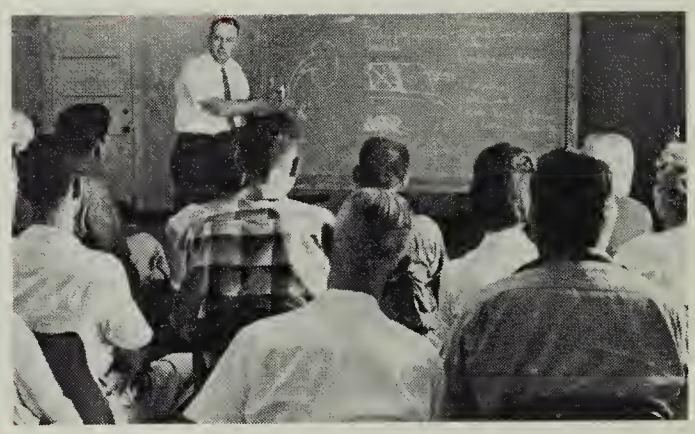
PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.



A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physicial examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $75 in cash or certified check only must be paid at the time of admission. No personal checks can be accepted! Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

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RALEIGH, N. C.

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Each patient should be provided continuity of treatment by a single team throughout all phases of therapy and treated on an individual basis.

Integration of Alcoholism and Other Addiction Programs

BY DALE C. CAMERON, M.D.

FOR me there is no easy answer to the question of the desirability of integrating programs for the treatment of alcohol-dependent and other drug-dependent persons. Consideration must be given to the level of integration as well as to place and time in which the program is to be carried out. Integration in the sense of treating all drug-dependent persons on a single ward or in a single day hospital or outpatient setting is a different issue than developing several different, closely coordinated treatment sources that may serve different patients according to their drug dependence, underlying psychopathology, social background, and legal status. Such a coordinated system of resources might also be seen as serving the same patient at different points in time as his "needs" change. The number of persons dependent on various drugs as well as the skills and attitudes of the physician and paramedical personnel who are or will be treating them are important factors to be considered in developing a solution for a particular community.

This paper was prepared for and delivered at the 16th annual meeting of the North American Association of Alcoholism Programs in Atlantic City, New Jersey, in September of 1965. It is published in *Inventory* by permission of the author and the NAAAP. Dale C. Cameron, M.D. is superintendent, Saint Elizabeths Hospital, Washington, D. C. The views expressed in this paper are his and do not necessarily reflect those of the Department of Health, Education, and Welfare.

About eleven years ago, I assumed responsibility for directing the mental health program of a state. Before my arrival, that state had developed special units for alcoholism in two of its eight mental hospitals. My initial reaction was that this was unnecessary, and a hardship for those patients who had to go long distances from their homes to obtain treatment. It was my view that any mental hospital ought to be able to and should treat patients with all types of mental disorders, including mentally ill alcoholics. I still believe this in theory, but the theory ignores the interests and skills of those responsible for the treatment, and the attitudes of staff, patients, and of the public. In fact, the specialized programs were doing a much better job for the alcoholics treated in them than was done for other alcoholics in most other mental hospitals in the country. That state at that time was not able nor ready to treat alcoholics requiring hospitalization in all of its mental hospitals along with other patients. The time for total integration of services for all types of mentally ill persons had not arrived. And even when, and if, all that state's hospitals are prepared to treat alcoholics, special programs within each hospital will probably continue to be necessary because many alcoholics present treatment needs calling for programs and activities different in some degree from many other patients. However, I would not wish to see all patients who abuse alcohol "fitted" into a Procrustean alcohol program any more than I would wish to see a woman, who, in a post-partum depression killed her child, treated in a maximum security hospital in a program designed primarily to meet the treatment needs of sociopaths.

Of course, we all recognize that drug dependence, whether to alcohol, sedatives, stimulants, or opiates, is almost always a reflection of some underlying mental and/or social disorder or pressure. The underlying mental disorders cover the entire range of psychiatric nosology. And the particular drug of abuse superimposes its own special physical, physiological, pharmacologic, psychological, and social complications and consequences. Ordinarily, drugs are abused in an effort to obtain "relief" from some "intolerable" psychological, social, or physical situation. It is the commonality of "escape through drugs," i.e., the utilization of drugs as a "crutch," that prompts us to consider integration of programs for all drug-dependent persons. Also, many persons who abuse drugs shift from one to another or use various combinations, depending on their availability and the desired effect of the moment. This, too, suggests consideration of program integration.

Patients Are Individuals

Some may consider it trite to observe (1) that each patient should be treated on an individual basis, taking account of his particular social, physical, pharmacological, psychiatric, and legal situation, and (2) that there should be continuity of treatment for each patient by a single team throughout all phases of therapy. I am risking such reaction because of my conviction that, while many of us give lip service to these concepts, we often behave as though motivated by other beliefs. We tend to set up "programs" based on a particular set of assumptions, develop methodology and procedures that sometimes seem to become ends in themselves, and expect each patient who comes in to adapt to our model.

(Continued on page 15)

Class Reading

My sociology teacher has read to our class from *Inventory* and I would like to receive it.

Student
Horse Shoe, N. C.

Wonderful For Some

It is with much interest that I have read *Inventory* for the past few years and have shared some of its contents with my friends. Your magazine presents many practical suggestions on almost every phase of the disease.

However, from my interpretation of your own and other articles on alcoholism, it seems as if most of the concentration is on education of the public about the disease, the causation of alcoholism, motivation of the alcoholic to stop drinking, and treatment during the first few days or weeks following withdrawal from alcohol. Then concern generally stops. Keeping the alcoholic sober is still left almost entirely to A.A. which is wonderful for some of us who can wholeheartedly accept the program, but not so good for others who cannot. However, your articles reveal that progress has been made in many areas.

Anonymous
Los Angeles, Calif.

Teaches Nurses

For the past thirty years I have been teaching nurses in China, Africa and Taiwan and find that I need more and more material to draw upon in my teaching. Your publication *Inventory* would be of immense value to us here in Taiwan.

Muriel Howell, R.N., M.S.
Taiwan Sanitarium and Hospital
Taipei, Taiwan

Wants More Information

I am an alcoholic—sober for quite a few years. Articles in *Inventory* frequently have been the bases for many of our most helpful A.A. group discussions.

The very fine article by Dr. Norman A. Desrosiers on "The Alcoses" prompted this letter. We feel his discussion of "Alcophrenia" merits greater emphasis and elaboration. Most of us seem to identify with this category.

Two of Dr. Desrosiers concepts of special interest to us concern the "self-preservation of the integrity of the ego," and the "temporary, chemically-induced schizophrenic syndrome."

Earl H.
Milwaukee, Wisconsin

Professional Library Use

Not only did we greatly enjoy the article "Alcopression and Alcophrenia" that appeared in the September-October issue of *Inventory,* but we feel it is important that we have copies in our professional library. Would you please let us know if copies are available?

We have an alcoholic rehabilitation center here, and treat about 450 cases a year.

J. D. Elred
Counselor on Alcoholism
Moose Lake State Hospital
Moose Lake, Minnesota

VOL. 15, NO. 4 INVENTORY NOV.-DEC., 1965

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

The Effects of the Alcoholic on the Family

ALCOHOLISM does not exist in a vacuum. More often than not the alcoholic is married and has a family. The nature of alcoholism is such that it usually has a rather devastating effect on the family members and on the general functioning of the family as a unit. Among the ways in which the alcoholic's family is affected, there are five areas which seem to be of the utmost importance. First, the alcoholic usually lets the family down by failing to assume his share of family responsibility. Secondly, the alcoholic's spouse is deprived of a satisfying emotional relationship. Third, the alcoholic serves as an improper model for his (or her) children. Fourth, his uncontrolled drinking affects the prestige of his spouse and children among their friends. Fifth, the alcoholic's drinking and the consequences of his drinking often affect the financial needs of the family.

Our modern family is faced with many perplexing problems in a changing society. Traditional sex roles are no longer so clearly defined, and in the family today there are many decisions to be made in which both husband and wife must share the responsibilities which society clearly delineates as being masculine or feminine.

Rather than being able to involve himself with family problems, the alcoholic often denies the existence of these problems, and relieves the tension and fear he feels by the use of alcohol. One patient told me that he could not tolerate having to worry about the family finances, so he left all of the decisions about money to his wife. When his wife wanted to talk to him about unpaid bills, allowances for the children, or any other financial matters, he would evade the problem by telling her, "It makes me nervous! I don't want to hear it!" or "Do whatever you want to do!" If the wife persisted, the husband would accuse her of trying to start an argument.

Certainly, this man is not assuming his adult responsibility to help solve family problems. We might

BY SHOBER A. ELLIS, A.C.S.W.

The spouse can learn to release the alcoholic to make it or fail on his own and begin to meet his or her own needs or the children's needs.

Reprinted from *Professional* by permission of the author who is chief clinical social worker for the Florida Alcoholic Rehabilitation Program.

describe him as a dependent person who is fearful of his duties as a husband and father. We know from his social history that this was his fifth wife. His present wife, like his previous wives, assumed the role of both husband and wife. What would happen if he quit drinking? He would certainly become more anxious, but he might find more constructive ways of handling his anxiety and at the same time be able to offer more as a husband and father.

All family problems are not money problems. In fact, there are constantly decisions to be made in all areas of family life in which one parent needs the support of the other parent. One example was an attractive woman patient in her early forties. She was married to a successful businessman, and they had two children—a son age 17 and a daughter age 15. Her husband told me that she would often get drunk before dinner and that he and the children would have to prepare dinner and put his wife to bed. The next morning he would bring her coffee in bed, because she was sick. Where did this leave the husband? He was trying to manage his business and his home and, also, trying to be both father and mother to the children. One might ask why he tolerated such a miserable situation. One reason was that there had been several happy years of marriage before his wife's drinking became uncontrolled, and he still cared for his wife. Secondly, he was not educated as to the nature of alcoholism, and his wife's drinking was in the advanced stages before he realized that she was alcoholic. Many husbands would not have tolerated such a frustrating experience, and there would have been a divorce.

The patients I have described are the more dependent type of persons who are fearful of assuming adult responsibility. Selden Bacon described another type of personality which we often encounter among alcoholics. He is the more aggressive, dominating, individual who is aware of his individual ability and seeks competitive situations so that he can win over others. He is usually selfish and cynical. In the family he is often a tyrant and highly opinionated. A casual observer might assume that the aggressive type takes on more than his share of family responsibilities, but he would be wrong. Actually, the family of today is a cooperative partnership which requires the mutual respect of husband and wife. The aggressive type is unable to cooperate and accept other family members. He is more likely to be concerned that the behavior of his wife and children glorify him than whether or not it increases their happiness and welfare.

As a Whole Person

This brings us to a second point. In today's family, we expect to meet our needs for affection, sex, prestige and acceptance as a person. At work a man may be a "cog in a wheel," but at home he expects to be king. A child may not excel in his school work, but he expects to be tops in his parents' eyes. We are living in a specialized society, and much of our life is compartmentalized. We go to school for an education, we join a garden club to pursue our interest in our work performance. The family is a social institution which treats us as a whole person, and it is in the family that one expects to find warm intimate relationships. The alcoholic, because of predisposing factors which have led to his present problems, is often unable to participate in family activities. Instead, he drinks to remove himself from hav-

ing to give and receive affection and from having to trust others.

Recently, the wife of one of our patients told me that while her husband was sober (which was eight years ago), they had a satisfying life together, but now she hardly has a marriage, except in a legal sense. For the past several years her husband has started drinking as soon as he comes home from work. After dinner he would retire to his bedroom, drink and watch television. The wife and children could watch television in the living room until bedtime. The couple has had separate bedrooms for the past two years.

This woman was certainly not receiving gratification of her needs for affection, companionship, respect and sex. The only alternative, if she was to stay married, was for her to sublimate her need for a gratifying emotional relationship in some other activity. In this case, she turned to voluntary community work, in which she found an outlet through helping other people.

Of course, there are some women who want to dominate and control, and perhaps a man who is alcoholic fits her needs. But this is seldom a happy situation. Her needs for affection and companionship still go unmet. And, although a man may want a woman who will be more of a mother than a wife to him, he usually resents his wife for his dependency on her.

One of the distressing problems of alcoholism is the effect on the children of alcoholic parents. To quote Ruth Fox, "That there is an enormously damaging effect we know from the constant references to behavior disturbances among the children of those alcoholics who reach the courts, mental hospitals, alcoholism clinics, private doctors, social agencies, ministers, and marriage counselors."

Where there is an alcoholic parent, there is almost always quarreling or fighting in the marriage. Parents may compete for the child's love and the child is sometimes torn between two parents. He may learn to work one parent against the other. The alcoholic father may be wonderful to his child sober and mean to his child when he is drunk.

The effects of an alcoholic mother on a young child cannot be overemphasized. When she is drinking, her behavior is not predictable, to the detriment of the child. The physical neglect is obvious. She forgets to feed the child, fails to keep the child clean, or sometimes leaves the child alone and without the care of an adult. Young children, of course, are completely dependent on adults for their physical care, and when these physical needs are unmet, the child's growth and development are adversely affected.

Emotional Neglect

The emotional neglect of the child, I suspect is even more harmful. The mother's own feelings of security and protectiveness toward the child are disrupted, both when she is drinking and when she is in a period of sobriety. When she is drinking, she is indulging her own feelings of dependency without being able to express love and tenderness toward the child. When she is sober, she has feelings of guilt of her excessive drinking and neglect of her child. Often she reacts to her guilt feelings by being overindulgent toward the child.

The child may grow up to have pervasive feelings of distrust, insecurity, cynicism, hostility and helplessness.

A child needs secure, consistent

(Continued on page 22)

The drug dependent person can be helped but only with an enormous expenditure of energy by the community resources of all professional and social groups.

PSYCHIATRIC ASPECTS OF

FROM the point of view of an increasing number of psychiatrists and other physicians working the field, what we term "alcoholism" actually represents a process of addiction. It is another manifestation of drug dependency, a very particular type of relationship established between the patient and some object or substance external to himself, in this instance, alcohol.

This concept, of course, merely characterizes the phenomenon. It does not designate etiology. Much research remains to be accomplished before we are able to speak knowledgeably of the causes of the addictive process. Contributions have come from many different fields of study and it would appear increasingly clear to be a multilateral etiological pattern. How much of the answer we will find from physiology and biochemistry, from sociology and anthropology, and from psychology, general psychiatry and psychoanalysis remains to be seen.

Be that as it may, however, I would like to offer today certain personal observations and impressions which I feel are pertinent to the task we have undertaken, equally applicable to the individual patient and to meeting with the community problem of the abuse of alcohol, narcotics and other drug substances.

It is the responsibility of the fields of medicine, psychology, social work and ancillary governmental and voluntary groups to meet and to work with any individual beset with this problem. It remains, though, the ultimate responsibility of each citizen of any community where such problems exist to demand the provision and financing of adequate facilities.

No single professional person, group, agency or organization can adequately, none-the-less totally, handle the many different problems relating to even a single case of alcohol addiction. To then ask a single profession or group to meet the community problem of addiction is totally unrealistic and futile.

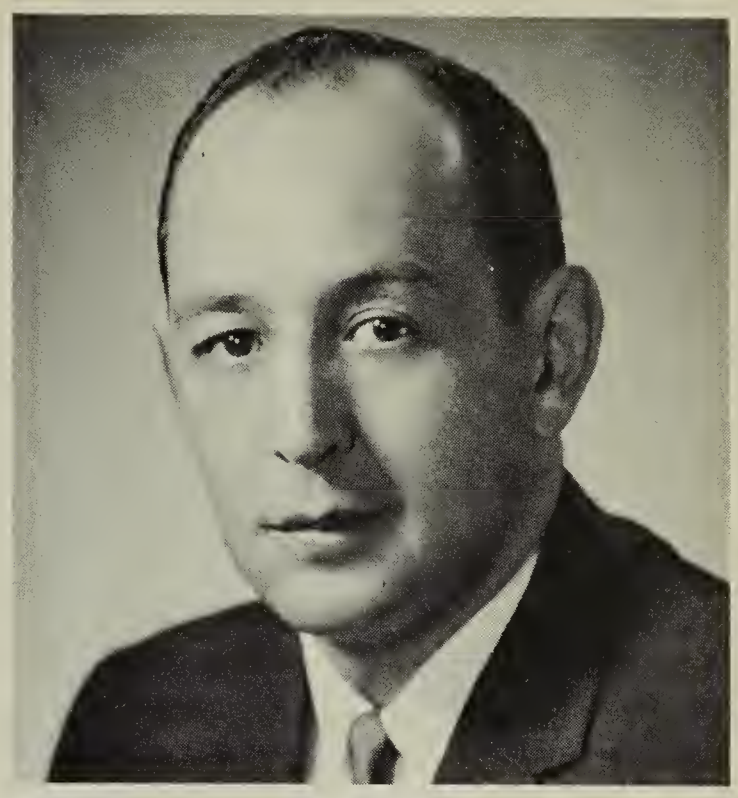
The mere use of alcohol or other drug and/or violation of any of the drug laws cannot be equated with addiction even if the use is periodic or intermittent. Each individual case requires a specific diagnosis.

Addiction, or "drug dependence" if we concur with the World Health Organization, is a medical syndrome,

BY

HERBERT A. RASKIN, M.D.

ALCOHOLISM



This article, published by permission of the author, was prepared for and presented to an American Medical Association Symposium on Alcoholism for the Oklahoma State Medical Society, Tulsa, Okla., April, 1965. Its author, Herbert A. Raskin, M.D. of Detroit, Michigan, is an associate professor of clinical psychiatry, Department of Psychiatry, College of Medicine, Wayne State University.

a chronic, relapsing sympton complex invariably reflecting some form of underlying mental disorder. The addicted person is suffering from a serious mental or emotional disturbance and manifests this disturbance in great part through his craving for and his relationship to the drug substance. Subject to the specific pharmacological characteristics of the particular substance upon which the individual has become dependent will be innumerable secondarily elaborated physical, physiological, psychological and social complications and consequences. We are all aware of the disastrous and calamitous potential of alcohol dependence.

The meaning of taking alcohol, narcotics, barbiturates or stimulants will vary from patient to patient and may serve different functions at different times for the same person. Dependence upon alcohol will be seen to operate in dealing with anxiety, guilt, aggression, inadequacy, depression, sexual urges, perversions, physical pain, psychoses, neuroses and character disorders. A great variety of psycho-pathological reactions are inextricably interwoven with the addiction process. Practically every entity in the psychiatric diagnostic nomenclature will be seen.

It would appear that the symptom of addiction, alcohol dependence, always represents a mode of adaptation, perhaps the sole adjustive mechanism to living problems the person has available at the moment. It is a symptom representation, a behavioristic reflection of some form of intrapsychic imbalance, conflict or excitation. It is a kind of last-grasping toward someting so as to forestall the horrors of inevitable disintegration, of psychic disorganization that spells the doom of total helplessness. The addicted person has found something that he knows will give him relief from unbearable tensions and anxieties. Even a strong wish to be rid of the drug substance is complicated by an even stronger fear of his real ability to function without it. To suddenly deprive him of this mechanism without replacing

it with something at least almost as effective is inflicting harm in the name of help. It is a refined form of cruelty.

I believe the whole host of varying psychiatric and psychoanalytic theories which have been propounded by many highly qualified investigators only reflects the variable psychodynamics of the particular patient groups studied. What constitutes stress and what type of intrapsychic conflict is producing tension and anxiety becomes a highly individual thing and may vary from one study group to another.

Pervading the clinical picture in most, if not all, cases of drug dependence, is an insidious, inexorable helplessness of the addicted person to deal with his addiction by himself. Through every stage of the development of the addiction the person we are dealing with is helpless to make an adquate adjustment by himself. His personality is characterized by serious defects in its development and pathological tendencies inherent in its structure. He is intolerant of anxiety. He avoids or escapes experiencing it through impulsive action. Before discovering the effects of drugs, his sense of security and well-being are dependent upon the immediate gratification of his needs and wants. The ordinary delays and inconveniences of daily living are experienced by him as intolerable frustrations, as crises. If through some kind of action he cannot escape them, unbearable tensions are experienced which he feels the environment should relieve. When the relief is not forthcoming, he feels that his inalienable right to happiness as a human being has been abrogated. Thus, simultaneously confronted with the irresistible need for immediate gratification and an ungratifying environment, it is inevitable that he will feel justified in employing any measure to rectify his deprivation.

The etiology of the addictive process resides within the psychological structure and functioning of the individual rather than in the pharmacological effect of the drug substance. Even if this person did not turn to the use of alcohol to relieve his tension, he would need help.

This need not necessarily preclude the possibility that there does exist some form of physiological predisposition in its etiology, the nature of which remains obscure and elusive. It may well be that some form of physiological receptivity contributes to dictating the specific object toward which the addictive process will be directed.

The social and cultural climate in which the patient lives may be even more significant a factor in the selection of the addictive object. It may be that given physiological propensity in an individual whose psychological growth and development predicate a need to reach out for some external object whereby tensions and anxieties can be met, one cultural group will allow the person to move toward alcoholism whereas another group makes it more likely he will move in another direction. Certain socio-cultural groups sanction alcohol as a solution whereas in others serious social conflicts exist which may precipitate even greater anxiety. Sociological studies demonstrate very different drinking habits and rates of alcoholism among various cultures and social groups. There are marked differences between various cities and sections of the country, and also between neighborhoods, social classes, religions and ethnic groups.

Once introduced to the drug, however, such a person will never forget its effects. The initial use of the

drug produces an incomparable sense of well-being, self-sufficiency and security. Problems no longer exist; decisions do not have to be made. The drug is the decision. The memory of this experience beckons as a panacea for all the unbearable frustrations of daily living. Once the alluring invitation is accepted, addiction is almost inevitable.

As in practically all instances of clinical pathology, addiction, drug dependence, is not merely an "either-or" condition. A person is not just "either addicted or not addicted;" he is not just "either an alcoholic or not an alcoholic." Drug dependence is a phenomenon that courses through a graduated continuum of degree of involvement or intensity of dependency from extremely mild to extremely severe.

Different Types

There are also different types of addicted persons. Variable factors coexist in various combinations as degree of craving, particular psychological pathology, physiological dependence and what has been termed "degree of total personal involvement." Each type will pose different problems of treatment and are quite likely to have different etiological histories and prognoses.

Variations also exist from patient to patient as regards level of motivation to live without the addicting substance, to be rid of it. Still further variations exist in the ability of the patient, the degree and type of ego-organization, to work toward such an aim, to be able to relate to a treatment staff, to be able even to accept any help that might be made available to him. Again, these variations run the gamut of possible degree.

Obviously, it is meaningless simply to identify an individual as an "alcoholic" or an "addict" or to speak in terms of a "typical alcoholic." It is completely erroneous to believe that these patients constitute any type of a really homogeneous group. Likewise, it is meaningless to think in terms of "the treatment" in cases of drug dependence.

We can, though, state a general principle of operation in the treatment of drug dependence. Each addicted person is entitled to respectful acknowledgment of his individual status as a human being and should be availed of complete medical, psychological and sociological assessment and evaluation. He should also be provided the best available treatment in terms of his particular psychological, medical and sociological needs.

In most instances, it would seem that reliance upon rehabilitative and control efforts on a voluntary basis is ineffectual, if not wholly futile. Strict and enforced supervision is usually required. But exceptions do exist.

In both private and clinical practice, I have treated alcoholic, narcotic and barbiturate addicted persons who sought psychiatric care because they perceived their own emotional illness and recognized that their addiction must somehow be related to it. Their motivation, sincerity and cooperation were good and the therapeutic results were excellent. In some instances, the patient actually withdrew himself through self-controlled administration of a gradually decreasing dosage of his own supply of the drug. Some cases required no specific withdrawal program because of the low level of physiological dependence. Other cases were withdrawn on an ambulatory, outpatient basis. In still others, hospitalization was required and the withdrawal was ac-

complished on the open medical ward of a general hospital. I must stress, however, that these addicted patients are far in the minority but not the inconsequential rarity as is so often posed.

The vastness of the problem dictates the development of community control programs. Such programs, in order to meet with the multiplicity of causes and compounding of complications, must be a multifaceted operation. It will require inpatient facilities, an outpatient clinic and community and neighborhood social casework services. All facets should be under a single, central administration with the same professional and ancillary personnel retaining continuing contact with the patient through all phases of program operation. Innumerable community resources, medical and social, must be recruited.

The hospital itself, in dealing with most patients, must be a specialized treatment facility insuring an environment free from contraband drugs. Its staff must be specially trained to meet with the many problems of acute withdrawal, physiological and physical care and treatment and psychological and social reorientation.

The basic goal of hospitalization is to initiate the restoration and facilitate the maintenance of physical and mental health. The patient must be returned to the community in as short a time as is possible, usually feasible within 4-6 weeks. Its role in the total treatment program is:
(1) Provide withdrawal and other medical care indicated.
(2) Secure psychiatric, psychological and sociological studies to gain an understanding of the functioning personality of each patient.
(3) In terms of this understanding, develop a patient-specific post-hospital treatment and rehabilitation program in concert with the requirements of the individual patient. All preliminary steps of implementation of his program must be accomplished prior to his discharge from the hospital.
(4) Opportunity for immediate readmission must be available.

Most usually, once the addicting substance has been successfully withdrawn, in a day to a week, the patient is frequently overwhelmed by a surging sense of confidence and optimism. In the protected environment of the hospital, with minimal instinctual tensions, absence of social pressures and free of the physiological dependence upon the drug, the memories of the pain and anguish precipitated by the frustrations of daily living become too dim and hazy to have real significance or to be the basis for the lesson that experience should have taught. Now sincere in the belief that he is able to take care of himself and tolerate ordinary frustrations like other people, he presses for release from the hospital. Usually neither logic nor reason can persuade him to remain in the hospital long enough to prepare himself for the inevitable trauma of emergence into the outside. It is just such an instance, which represents the preponderance of addicted patients, where the instrument of civil commitment may be of value to the patient.

A great deal of controversy exists in relation to the role of civil commitment in dealing with problems of drug dependency. The experience of many would seem to indicate that it has a vital role to play in a large number, perhaps the majority, of cases. But this does not mean that

the patient is to be sentenced to a State Hospital for being mentally ill in lieu, perhaps, of going to jail. It need not mean State Hospital at all. As a matter of fact, it is my belief that a purely institutional setting, hospitalization on either a court committed or wholly voluntary basis, by itself, especially for a prolonged period of time, promises little in the direction of success. Hospitalization must be viewed as but one facet of a total treatment program. It has a very specific role to play but by no means constitutes *the* treatment of any problem of drug dependency. The instrument of civil commitment is viewed as just that, an instrument. It is another tool available to the treatment and rehabilitation staff in its effort to help the addicted patient to help himself. It is a tool to be used where indicated and to be applied throughout all phases of rehabilitation, hospital, outpatient and community follow-up social casework. It need not prolong the period of hospitalization beyond that dictated by the immediate requirement of any given case at any given moment in the course of his illness.

Outpatient care, whether accomplished in a community program clinic or the office of the private physician, must include psychotherapeutic services and social casework with the patient and, in almost every case, with the patient's spouse and family. Psychotherapy must be available in whatever form and on whatever level is determined to be required and applicable to the individual patient.

In most instances, these patients are very poorly motivated for treatment, psychotherapy or general medical care. They will vigorously deny the status of being an "alcoholic," even in the face of serious physiological malfunctioning and organ damage growing out of the abuse of alcohol. This will often hold true even when hospitalization has been required for these same causes. They are even more denial-prone in relation to the existence of any type of emotional disorders and quite insistent that there is no need for any form of psychiatric help. Motivating them for treatment is extremely difficult at best and requires great patience. Citing the evidence in the patient's history, experience and behavior and seeking to instill fear with a direful prognostic picture usually does not work. These people have all the answers and are able to rationalize all experiences with great keenness. By using such technique, we also run the risk of arousing high levels of overt anxiety in our early contact and cause the patient to flee from us back into the protection of alcohol.

Winning the trust and confidence of the patient constitutes the first major task to be accomplished. The understanding, nonjudgmental, nonmoralizing acceptance of the patient as a sick person is essential for any of the treatment personnel. The physician and any ancillary aid he will require must demonstrate an active interest in the patient, indicate his siding with the patient in his struggles. No progress can be expected until the patient has become convinced of this. Actually, we are trying to establish a kind of relationship with this person that he probably never before in his life experienced. The physician must identify and acknowledge postive aspects of the patient's personality and behavior

so that we are not just another criticizing authority to him. These patients have been lectured to and scolded for years by parents, spouses, friends, employers; probation officers; they are hypersensitive to criticism, which has come to signify rejection. Rapport is also more easily established if the therapist uses the patient's own language and avoids the use of professional jargon.

Throughout all our contact with these patients we must be constantly alert to our own emotional responses to the manipulations, resentments, extreme demandingness and all the various manifestations of an infantile dependency posed by them. Direct advice and even active intervention will be indicated in dealing with many reality living problems. Time and appointments mean little; regulation and administration of medications will be often used as aggressive weapons against the therapist; demands for extra attention, medications, and special considerations are to be expected. Comparable requirements will be exerted by the patient's families also. And throughout it all we must be consistent, steady, honest, noncorruptible, always keeping our word in whatever we might promise the patient. We must recognize that the illness is of a relapsing nature and that "falling off the wagon" and resorting to drinking does not constitute therapeutic failure. Our level of tolerance for all forms of behavior must remain high even when we can see that it is being utilized as a testing device in their feeling us out. This is even more true when the patient utilizes his drinking as a direct challenge to our attempts to help him. Patterns of self-destructiveness in overt and covert methods must be recognized and dealt with.

It is too often found that the physician rejects or will not accept the drug dependent person as a patient on the basis that he is too busy to bother with someone who does not want to help himself and, anyway, he has more important things to do with his time. What we usually mean by this is that I can find much more rewarding and gratifying patients to work with. I grant that this is true but it does not deter us from our medical responsibilities.

Our responsibility to our drug dependent patient, however, goes far beyond medical care. Each of us will require the enlistment of aid from paramedical and ancillary groups in effectuating the social rehabilitation that is always required. But social rehabilitation must be a community, even a neighborhood centered function. This activity cannot be served in the hospital or offices of an outpatient clinic or a private practitioner. On-the-spot, neighborhood contact is deemed to be essential. Many different community social and welfare agencies will have to be utilized to meet the many ramifications of living problems. If these requirements are not met relapse to drug abuse is almost inevitable.

Organizations such as Alcoholics Anonymous, Big Brothers, Addicts Anonymous, in a 1:1 ratio with the drug dependent patient, can act in assistance with the social service staff. The clergy, religious groups, various businessmens', fraternal and citizen's groups also have important roles to play. And let us not forget the public health nurses, parole and probation officers.

I must emphasize the importance of all such planning being accomplished prior to discharge from the hospital and a kind of "reaching-

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If his needs do not fit our model we say that his is a problem for others. If he is accepted for treatment and never shows up, or drops out prematurely, he is "refractory to treatment." He may well be refractory to our methods and procedures. In this case, should we ask him to change his problems, or ourselves to change our methods when trying to help him? How often do we change our hours to accommodate the patient, our admission procedures, or the theoretical basis of treatment when one approach is crowned with notable lack of success?

I suppose what I'm trying to say is that, in my opinion, one does not have a program for alcoholics, or any other drug-dependent group, if only one treatment modality suitable only for certain self or staff-selected patients is available. This is a project or a facet of a total program. It would seem worthwhile to develop a reasonably complete program providing the entire process of case finding, psycho-social evaluation, detoxification, psychiatric, and other medical treatment, social and vocational rehabilitation and follow-up.

This program should be so designed that a central therapeutic team would provide the necessary continuity of treatment throughout the entire process, utilizing the direct and consultative services of others in dealing with such special problems as detoxification, elective surgery, and vocational training. It should also be so designed that a variety of treatment and case finding methods appropriate to patients' differing social situations, motivations, and insights may be utilized. It should recognize that certain "middle class" persons may be driven away from the program if forced to mingle for prolonged periods with persons given to unlawful activity and earthy expressions, and that the latter may have a very negative reaction to "squares." However, in some instances mingling of selected patients may be quite helpful.

If, in your locality, there are few narcotic addicts and little access to illicit drugs, I would see no reason why they should not be detoxified on the same medical or psychiatric ward utilized for alcohol or barbiturate detoxification. If there are numerous narcotic, as well as other drug-dependent persons to be detoxified in your community, then perhaps you can afford a special ward or service for this purpose. If the same patient who has been seen as an alcoholic by a central treatment team returns abusing narcotics or *vice versa,* I would want the same team to continue on his case, even if he were housed on a separate ward. And I would want them to see him later in the day hospital, outpatient clinic or on home or work visits when further contact is indicated.

It is realized that this is somewhat idealistic and difficult of achievement where many agencies and persons are involved. But it is the pattern for which I would strive.

If your program is large and you have separate wards or services and a variety of approaches for different categories of drug-dependent persons depending on their drug of abuse, social or legal situation, but provide for continuity of treatment, I don't know whether you should call it "integrated" or not. If the program is small, but provides for continuity, it would probably be said to be "integrated." In either event, you might justifiably be entitled to a certain sense of pride and accomplishment.

THE IMPACT OF ALCO
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The role of Al-Anon is to restore the family by healing nonalcoholic family members thereby creating a climate in which the alcoholic may face reality and accept treatment.

BY
Henrietta S.

This paper was prepared for and delivered at the 16th annual meeting of the North American Association of Alcoholism Programs in Atlantic City, New Jersey, September, 1965. It is published in *Inventory* by permission of the NAAAP and the author who is executive director of the Al-Anon Family Group Headquarters, Inc., P. O. Box 182, Madison Square Station, New York, New York, 10010.

THE Al-Anon Family Groups are a fellowship of relatives and friends of alcoholics who share their experience, strength and hope with each other in order to solve the problem of living with an alocholic.

We accept the fact that alcoholism is an illness which can be arrested. We have demonstrated that changed family attitudes can bring about recovery.

The only requirement for membership is that there be a relative or a friend with a drinking problem. There are no dues or fees for membership; Al-Anon is self-supporting through its members' own voluntary contributions.

Al-Anon is not allied with any sect, denomination, political entity, organization or institution; does not wish to engage in public controversy; neither endorses nor opposes any cause. Our primary purpose is to practice the Al-Anon program in order to help others with similar problems, aid the alcoholic through understanding, and grow spiritually ourselves.

The Family Group idea is nearly as old as Alcoholics Anonymous. In A.A.'s pioneering days from 1935 to 1941, close relatives of recovering alcoholics realized that, to solve their personal problems, they needed to apply the same principles that helped alcoholics.

As early A.A. members and their wives visited A.A. groups all over the country, the visiting wives told the mate of the newer A.A.'s about the personal help received when they themselves tried to live by A.A.'s Twelve Steps, and how this improved difficult family relationships which often persisted even after the alcoholic had become sober. Thus mates and relatives of A.A. members began to hold meetings to discuss *their* common problems.

By 1948, numbers of Family Groups had applied to the A.A. General Service Office for listing in the A.A. Directory, and scores of distracted relatives of alcoholics had asked them for help. But A.A. was de-

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OLISM ON THE FAMILY

E of AL-ANON

BY

REV. JOSEPH L. KELLERMANN

The family is literally crushed as the illness of alcoholism advances because so few families find adequate help, including a basic philosophy on how to reduce alcoholism.

This paper was prepared for and delivered at the 16th annual meeting of the North American Association of Alcoholism Programs in Atlantic City, New Jersery, September, 1965. It is published in *Inventory* by permission of the NAAAP and the author who is director of the Charlotte Council on Alcoholism, Charlotte, N. C. These two papers with identical titles were delivered at the same session.

A subtitle, or an alternate title, might be The Souse's Spouse, Alcoholism's Tragic Victim. The children of the family are also victimized by this illness but this injury may be minimized greatly if the spouse learns how to cope with the illness and interpret to the children what is happening. As few husbands of alcoholic wives are willing to attempt Al-Anon, for purposes of explaining the role of Al-Anon we shall think in terms of the alcoholic husband although the basic principles apply to the alcoholic wife as well.

It is imperative to think in terms of alcoholism rather than alcoholic for this is an illness of two or more persons. Dr. Seldon Bacon states that alcoholism cannot appear in isolation, progress in isolation nor maintain itself in isolation. It is the interaction of two or more persons. The person drinks in an abnormal fashion. Others react. The drinker consciously or unconsciously evaluates and responds to the reaction. The person drinks again, thereby completing the downward spiral termed alcoholism. In this cycle, the reactions of those other than the drinker may be just as compulsive as the drinker's drinking.

A workshop on the alcoholic soldier done at Walter Reid Hospital in 1963 described the primary actors in the tragic drama of alcoholism as follows: One is the enabler, a guilt laden person, who rescued the alcoholic from the crisis caused by drinking. It may be a member of the family but in most instances it is a person completely outside the family; a minister, doctor, lawyer or friend. Time does not permit discussing this person at length but this person accepts the promises of the alcoholic and reassures the community and family that this will not reoccur. The second actor is the victim; the boss, the business associate, the commanding officer who depend upon the alcoholic. The alcoholic is a member of society as well as the family and this person or persons submit to repeated victimizations. The wife and at times the mother as well is de-

scribed as provocatice, the female provoker, who is bound to the alcoholic in a destructive interaction. To understand this character in the drama, especially the mother, examine the role of the Father in the story of the Prodigal Son. Change the sex and reverse completely the characteristics of the role and we have the provocatice. The alcoholic is the fourth actor in the drama.

This transfer of the tragedy to a stage rather than viewing the alcoholic in a sick bed enables us to understand more clearly the impact of alcoholism on the family. It is imperative to understand that the role of the wife in the play is strongly influenced by all three actors, not the husband alone. Perhaps it is important enough to examine what these persons can do to enable the play to run indefinitely rather than replacing the tragedy with a different type of play called Recovery.

Effect on Wives

One way of describing what happens to the wife of the alcoholic is to say that it is as if she were caught in the jaws of a bench vise. The heel of the vise is bolted to the bench and this we shall describe as marriage which she has been conditioned to accept as a lifelong relationship. The other jaw of the vise is alcoholism which progresses as the patient continues to drink. As this jaw of the vise advances the wife may be crushed and utterly destroyed. Shame and stigma, the cultural attitude toward alcohol and alcoholism prevent most wives from breaking through the advancing illness. Studies indicate the average wife refuses to admit that her husband is an alcoholic until the illness has been critical for seven years and then waits two more years in seeking professional help.

If we examine the chronology of the illness we see that the prodromal phase begins with the appearance of alcoholic amnesia at the mean age of twenty-nine. Compulsive drinking appears at the mean age of thirty-three and curing the hang-over with the morning drink at about thirty-five. Binges or staying drunk does not appear until the mean age of thirty-eight to forty. During this span of progress from prodromal to chronic alcoholism the society in which the family lives rarely recognizes the husband as a alcoholic. The nature of the illness is a process of denial on the part of a very immature and dependent person. The alcoholic discovers by chance or experimentation that nonspecifically alcohol dissolves anxieties, reduces tension, releases hostilities and solves all problems but for the time being only. It gives him such a sense of security, well-being and success that once he discovers this magic effect of alcohol as a medicine he never forgets it. Problems do not have to be solved, choices do not have to be made. Alcohol becomes a combined choice and answer. The whole subjective world changes with the ingestion of alcohol. A Dr. Jekyll and Mr. Hyde change occurs in the alcoholic. The outside world sees Dr. Jekyll, the family lives with both Jekyll and Hyde. Dr. Jekyll denies what is wrong by getting drunk and Mr. Hyde does not care what is wrong; in fact tends to tell his wife that everything wrong with the marriage is her fault.

The relief of chemotherapy is not afforded the wife unless she too becomes an alcoholic. In the pain relieving mechanism of intoxication of the husband the wife's emotional pain is multiplied. Deviate behavior attacks her from two sides: first the direct result; secondly the efforts to

conceal deviate behavior because its revelation appears to her to be an admission of failure in her marriage. The alcoholic is not an innocent victim of alcohol but a person capable of disrupting the entire social order to gain immediate relief for himself. If you prefer other terminology, alcoholism is a profound form of emotional illness which is relieved by drinking excessively. Regardless of what we think (to the alcoholic) this is for the moment the only medication which brings relief. Alcoholics do not drink, they medicate. This is the only illness named for a patent medicine which the patient consumes in overdoses.

During this average span of about ten years as nonremittent alcoholism progresses from the prodromal to the chronic stage, the alcoholic, and society — including most professional persons—will not accept the reality of the illness. During this period if the wife overcomes her shame and embarrassment and seeks help from professional persons, rarely does she find help commensurate with her needs. When the wife turns to the minister, doctor or lawyer, she may not find a person who understands alcoholism because many professional men have gone through their entire period of training without one single hour of objective instruction on the subject of alcohol or alcoholism. In our cultural attitude toward alcoholism these professional men often play the role of the enabler. If she seeks help and does not receive adequate insight, understanding and assistance, her sense of hopelessness is increased, not diminished.

Our present society with its cultural attitude toward alcohol and alcoholism does not recognize the prodromal stage as true alcoholism. As the wife is part and parcel of this culture, she does not recognize it either. The patient without interruption moves into the compulsive stage of drinking behavior called crucial alcoholism. Even at this point the wife receives little help. Treatment of alcoholism today is largely treatment of the chronic acute condition of the alcoholic, sometimes followed by inpatient or outpatient therapy for a period of time but with little or no treatment for the wife and family.

If this illness can not appear, progress or sustain itself in isolation it can not be treated in isolation. To return to the stage and look at the tragic drama again. If the enabler, the victim and the provocatice change their roles and reverse their reaction to the alcoholic behavior by allowing this person to come face to face with the full, unpleasant consequences of his behavior, then the probability of recovery is high.

Dr. John W. Ewing of the University of North Carolina has been engaged in the treatment of alcoholism for some fifteen to twenty years. In studies he has conducted it is evident that profound changes may occur in the alcoholic if the wife undergoes therapy. In a study of thirty-two wives who entered into treatment with Dr. Ewing while husbands were active alcoholics: sixteen husbands stopped drinking altogether, six made good improvement, five made fair improvement and only five failed to respond. Dr. Ewing states that if the wife seeks and secures competent help and works at her own therapy it can in many instances produce a long-range recovery of an alcoholic husband.

Let us now look at what happens when the victim of the alcoholic changes costume and character. In the Milwaukee Plant of Allis-Chalmers during the past twenty-one years, their alcoholism program under the

direction of the personnel services department, has secured a record of ninety-two per cent recovery from problem drinking. All possible assistance is offered the alcoholic, the wife through counseling and Al-Anon is included in the recovery process, and foremen, supervisors and managers are educated and trained to initiate the program of recovery rather than to act as enabler in the perpetuation of the illness.

In a less structured program conducted by DuPont in Wilmington the recovery rate of those persons to whom the program of rehabilitation is introduced by the company is currently sixty-nine per cent.

The real tragedy in alcoholism today is failure to meet the needs of the family, not only from the point of therapy but in providing support if the wife chooses to accept help and attempt to reduce or arrest alcoholism.

Impact on Families

Let's look at the impact this illness has on most families. A clear revelation of this is portrayed in Dr. Joan Jackson's article "The Adjustment of the Family to the Crises of Alcoholism." First the wife tries to deny the drinking problem; secondly to avoid drinking situations for her husband. This fails and finally life becomes a period of chaos and confusion with extreme injury to children. The fourth period occurs when the wife becomes the head of the house to restore some order. Fifth there is attempted escape from the situation by withdrawal or excessive activity and often there appears a condition which I describe as divorce within the home. Step six is termed separation or rearrangement of the family without the alcoholic. Seventh is reconciliation, the most difficult step of all, successful only if the alcoholic has entered into treatment and remains active in a recovery process for a period of years. The key in understanding the word impact is the word adjust. The family is literally crushed by this advancing illness because so few families find adequate help, including a basic philosophy on how to reduce alcoholism.

Dr. Gordon Bell states that the alcoholic is locked in a phase of resistance to treatment and unless someone breaks that lock most will die without being able to admit they need help. In my last parish alcoholism resulted in death for one per cent of my adult communicants in a five-year period. These parishioners had good doctors, excellent hospital care, some entered treatment centers, one or two attempted psychotherapy, and two attended A.A. meetings for a period of time. Looking back I see all too clearly the focus of attention on the alcoholic without any basic attempt to change the family and its involvement in the problem. The family also was locked in a phase of resistance to change, due largely to the cultural attitude of our society toward this problem combined with basic misconceptions of how recovery is effected.

All my alcoholic parishioners did not die from this illness. One wife of an alcoholic saw what happened to her alcoholic brother and his wife, determined it would not happen to her family if she could prevent it, and offered her husband the choice of recovery or separation. She did this in the agony of loving her husband and wanting to remain his wife, knowing it could happen only if the illness were arrested before both were destroyed. The illness was arrested. Another lost his wife and children by separation, recovered too late to re-establish his former mar-

riage and entered into a second marriage in which abstinence has been maintained for years. One thirty-five year old bachelor was able to recover only after the death of his seventy year old mother who had for years played three parts in the drama, enabler, victim and provocatice, by allowing the son to live with her without working.

Each case of alcoholism is different and each recovery process has its infinite variations but there are basic common denominators:

1. It takes two or more persons to produce and sustain alcoholism, therefore recovery is a product of two or more persons becoming involved in the process.

2. Waiting for the alcoholic to want help is fatal and generally results in untimely death of the alcoholic. In the process the wife and children are destroyed emotionally if they do not separate or receive competent help.

3. Purely voluntary programs of recovery are rarely successful for the alcoholic. Recovery should be structured, something we should have learned from A.A. long ago, and should continue actively for two to three years before regular active therapy may be reduced.

4. The earlier the discipline of treatment is initiated the better the probability of recovery and this should begin in the prodromal stage and never later than the beginning of the crucial stage of the illness. However this rarely occurs. Involuntary treatment as a legal procedure can not be effected until the chronic stage is reached.

Add these four together and the total reveals what I have tried to present as the impact of the illness on the family of the alcoholic. Alcohol is the psychological blessing to the alcoholic and physiological curse leading to death. Unless the family through adequate help learns to understand their own involvement, seeks help for their own emotional distress, and establishes a disciplined program of recovery, the wife and children will be destroyed emotionally, economically and eventually as a family. In my state the divorce rate in alcoholic families is eight times the average divorce rate. I do not know the rate of early widowhood but the life expectancy of a chronic, unrecovered alcoholic is in the early fifties.

The role of Al-Anon may be described elaborately or simply. The best method of description I can find is that it stands today in regard to the needs of the spouse of the alcoholic in much the same position A.A. stood in relation to the alcoholic a generation ago—the only resource generally available for a family member who wants help in the recovery from alcoholism.

Al-Anon may be termed a fellowship of recovering wives of alcoholic husbands which enables the new member to change her role from that of provocatice to that of wife. All wives in alcoholic marriages are forced to be nurse, doctor and amateur psychiatrist in the care of the alcoholic husband. In this role they are complete failures and perpetuate the illness because none of these goals may be achieved by the spouse. Through the group experience of Al-Anon she may learn to forfeit these roles and learn to be wife, housekeeper and if needs be breadwinner without supporting the drinking pattern.

Al-Anon also provides a community of understanding in a cultural and intellectual vacuum which exists to a large degree in our present society as regards alcoholism. Until the chronic stage of the illness is reached in which the alcoholic be-

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EFFECTS OF THE ALCOHOLIC

CONTINUED FROM PAGE 7

parents who are sincerely interested in his welfare, who will guide him in growing up. Alcoholics, of course, are not secure, and they are not consistent. The alcoholic has difficulty in understanding the rules by which we are governed as a society, so it is difficult for him to teach his child. He often feels either dependent and helpless, or competitive and defiant.

I think that the greatest harm resulting from alcoholism is the failure to provide a proper adult model for the children. How is a boy going to learn to be a man if his father is alcoholic and serves as an improper model? How is a girl going to learn to be a woman if her mother is alcoholic? Many children of alcoholics do overcome these disadvantages, but certainly it is not easy for them. Others, as I have already mentioned, suffer serious emotional harm.

The alcoholic's behavior affects the prestige of his wife and children among their friends and in the community. We have the stereotype of the alcoholic who gets drunk at a social gathering and becomes boisterously loud, insults the hostess and in general makes a fool of himself, after which he passes out and has to be carried home. In my conversations with alcoholics and relatives, I find this to be atypical. Rather than a wild social life, there is more likely to be no social life at all. However, it is not uncommon for the alcoholic to resent his wife's having friends, or to embarrass her when she has friends in their home or arranges for them to go out.

The children may be embarrassed by intoxicated parents when their friends visit the home. Their friends may tell their parents, and the parents may not allow their children to visit again. In this way an alcoholic can often force his family, as well as himself, into social isolation.

Our last area of concern is the economic effect the alcoholic has on the financial needs of his family. Alcoholics come from all economic levels, all have difficulty functioning in their work. The most common cause of alcoholics' losing their jobs is absenteeism. The alcoholic goes on a bender on the weekend, and he has too much of a hangover on Monday to report to work. Often, the threat of losing his job will cause him to seek help with his drinking problem. He will see that he is going to lose his job unless he stops drinking or he has already lost one or more jobs because of his drinking. When the alcoholic begins losing jobs, his family feels the effects of financial insecurity.

Real Need for Help

In view of the devastation which the alcoholic inflicts on his family, the family often has a real need for help. Persons who work with alcoholics need to work with the families of alcoholics, or refer them to appropriate agencies where they can receive help with their problems.

In working with the family, we frequently can indirectly help the alcoholic. When a member of the alcoholic's family seeks assistance with a problem, he or she is first of all bringing the problem out into the open. Until a family member is troubled enough to seek help, the alcoholic's drinking pattern is protected from any outside intervention. Often the family has been disrupted and thrown into a quandary long before anyone seeks professional help.

How can we best help a family member who is seeking help? First,

we have to recognize how difficult it is for the spouse, parent, child, of the alcoholic to seek help and how troubled they are when they finally decide they can no longer cope with the alcoholic's drinking. We can acknowledge to the client that we know how difficult it is to express her problem to us. Such an acknowledgment, if genuinely expressed, gives the client a feeling of being understood and allows her to feel freer with us.

The next step is to try to understand the kind of help the spouse is seeking. Usually, the spouse wants us to help the alcoholic to achieve sobriety, which, of course, we cannot do unless the alcoholic desires help for himself. We can often clarify this with the spouse by asking, "Does your husband recognize that he has a drinking problem?" In the beginning, the wife or husband of an alcoholic seldom recognizes that he needs counseling himself. Whether or not the spouse had emotional problems before marriage makes little difference, for her husband's excessive drinking has certainly affected her emotional well-being. And, if she can handle her own inner problems, she can be more objective in relating to her husband. Often the spouse of the alcoholic has been in the role of helper, and she must be assisted in making the transition from that of helper to that of being helped.

The alcoholic in the more progressive stages of alcoholism usually wants help, but at the same time, does not want help. The spouse of the alcoholic can force the alcoholic into treatment either by pleading or threatening — sometimes threats of separation or divorce will motivate the alcoholic to superficially enter treatment—but rarely is he actually involved and committed to achieving sobriety. But the spouse of the alcoholic can, in a counseling relationship, learn to let go of the alcoholic and begin to meet her own needs or the children's needs. In surrendering to what she cannot control, she releases the alcoholic to make it on his own or fail on his own. He can no longer excuse his drinking on the premise that his wife nags him, and it leaves the problem where it belongs—with the alcoholic. At the same time, the spouse's creative energies are released to meet her own needs and those of her children.

To summarize, the family of the alcoholic needs help as much as the alcoholic. We can help the family by listening empathetically to their problems and thereby demonstrating our deep and sincere concern for them. Secondly, we can recognize that the family, and particularly the spouse of the alcoholic has been in a quandary and has a need to emotionally lean on someone instead of being leaned on.

Third, we need to recognize that the spouse of the alcoholic does not know what kind of help she is seeking. Often we have to assist her in recognizing that there is not anything that she can do or that we can do directly to force the alcoholic to stay sober. But she can find help herself and thereby free the alcoholic from a hostile, dependent relationship, so that he may become motivated to seek help himself.

Fourth, we need to understand the nature of alcoholism so that in the counseling relationship we can explain to the family what is happening and what they may expect to happen. If we can meet the troubled family of the alcoholic, utilizing the four preceding points, we are well on our way to helping a troubled family confront and overcome a crisis which threatens to destroy them.

A feature designed to help you keep posted on developments in the field of alcoholism.

CORRECTION: The What's Brewing feature of the September-October, 1965, issue of **Inventory** contained a photograph of the 2nd place winner in booth competition of the 1965 Employees' Field Day of the N. C. Prison Department. The 2nd place winner in the presentation was mistakenly attributed to the 8th division. It should have been the 6th division. The 8th division actually was the contest's first place winner.

SANFORD, N. C.: New officers of the Alcoholism Programs of North Carolina, elected at the annual meeting held October 21 and 22 at the Personnel Training Center of the N. C. Prison Department, are: Marshall Abee of Winston-Salem, executive director of the Alcoholism Program of Forsyth County, president; Michael Dechman of Asheville, educational director of the Alcohol Information Center, vice president; Mrs. Margaret Brothers of Burlington, executive director of the Alamance County Council on Alcoholism, secretary-treasurer; and William Hales of Charlotte, associate director of the Charlotte Council on Alcoholism, member-at-large on the Executive Committee. All officers serve two-year terms.

FEDERAL LEGISLATION: Major legislation to cope with the alcoholism problem in socio-medical terms has been introduced in both the Senate and House of Representatives. This represents a breakthrough in the efforts of the North American Association of Alcoholism Programs, the Christopher D. Smithers Foundation, and the National Council on Alcoholism to secure greater Federal responsibility for the alcoholism problem. The September 28-29 House hearings were extremely successful, and further hearings are expected to be conducted in the new session of Congress.

JOINT PLANNING: The Executive Committee of the Alcoholism Programs of North Carolina and the Liaison Committee of the N. C. Department of Mental Health met in Raleigh December 3 to develop plans for a workshop for APNC members and DMH personnel. The workshop will be conducted at John Umstead Hospital, Butner, N. C. on February 24, 1966. The plans are to follow the workshop with a series of regional workshops which will involve a variety of community agencies as well as APNC members and DMH personnel. The Executive and Liaison Committees will meet on February 25, 1966, to plan the regional workshops. The Executive Committee members are Marshall Abee, Winston-Salem; Worth Williams, Greensboro; Michael Dechman, Asheville; Mrs. Margaret Brothers, Burlington; and William Hales, Charlotte. Members of the Liaison Committee are: Dr. R. J. Blackley, chairman; and doctors Nicholas Stratas, Charles Vernon, N. P. Zarzar and Norbert Kelly.

ALCOHOLISM INFORMATION WEEK: The complete text of Governor Dan K. Moore's statement designating ALCOHOLISM INFORMATION WEEK in North Carolina follows: "I am happy to designate the week of November 28-December 4 'Alcoholism Information Week in North Carolina' because it gives me a chance to participate in this very worthwhile national-state-local educational effort focused on our 4th major public health problem.

"One of our greatest needs in dealing with alcoholism is a unified set of attitudes toward the sick person known as an alcoholic and his illness which we call alcoholism. Our society, for example, treats many alcoholics as criminals instead of patients by putting them in jails and prisons instead of hospitals. The American Medical Association recognizes alcoholism as a disease, yet many doctors will not treat, and many hospitals will not accept, alcoholics as patients. Alcoholism is a treatable personal and family illness, yet many victims and their families refuse to seek help because our society by its deeds implies that 'nice people just don't get this disease.'

"Such inconsistencies, and there are others, are major drawbacks to alcoholism control efforts, but we, as citizens, can do something to eliminate them. We can participate in ALCOHOLISM INFORMATION WEEK, change our attitudes when they need to be changed, unite our efforts, and express in word and in deed our conviction that alcoholism is an illness and the alcoholic is a sick person."

Governor Dan K. Moore passes a copy of his statement designating November 28-December 4 "ALCOHOLISM INFORMATION WEEK IN NORTH CAROLINA" to Dr. Eugene A. Hargrove, State Commissioner of Mental Health. Looking on is Marshall Abee of Winston-Salem, president of the Alcoholism Programs of North Carolina. Alcoholism Information Week in North Carolina was sponsored by the National Council on Alcoholism, the N. C. Department of Mental Health, and the local alcoholism programs throughout the State.

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signed to aid alcoholics only and did not wish to be diverted from its primary aim.

In 1951, one father and several wives of A.A.s in the New York area formed a Clearing House Committee to get in touch with these inquirers and to coordinate and serve the then-existing fifty groups. As a result of questionnaires, the name "Al-Anon Family Groups" was chosen. The 12 Steps of A.A., virtually unchanged, and the 12 Traditions, were adopted as guiding principles. Our goal was unity of purpose.

Soon the movement came to public attention. New groups and individuals, here and abroad, wrote to the Clearing House about their problems. I heard about the Family Group about a year after my husband joined A.A.

Jack did not seek sobriety of his own volition. In 1943, he was forced to attend a few A.A. meetings at the insistance of his employer, but did not sober up. He just became wilier at concealment on the job. Subsequently, because our son at age five had suddenly developed a speech difficulty, with no such tendency previously noticeable, I broke down at the question of our pediatrician concerning any unusual tensions in the home, and tearfully confessed that my husband drank too much. At his suggestion, Jack tried psychiatry, though unwillingly. He said *I* was the one who needed treatment. The six months of therapy were expensive and completely ineffectual, because he drank the whole time with a vengeance. There were periods of remission after that, spells of comparative calm and even times of genuine family happiness, but there was always that sword of Damocles casting a shadow over the future.

It is still inconceivable to me that an alcoholic can drink up as much money as mine did. He was a newspaper editor on his way up, with a real flair for subtle humor. In order to help finance the last five years of his drinking, he also wrote fact fiction detective stories at night, fortified by a bottle of whiskey beside him. Even a sizable inheritance from my father, which I tried to keep intact as a reserve for the uncertain future, went down the drain of alcoholism. But to be truthful, I helped spend some of it. After months of penny pinching, when suddenly faced with yet another batch of drinking tabs to pay, I would rebel and make extravagant purchases that we could ill afford, if we were ever to educate our children.

Threats of Separation

I threatened separation on numerous occasions and Jack retaliated by promising to skip the state if I went through with it. Once I went so far as to consult a lawyer, but subconsciously, I was not ready for separation. I chose a counselor who was a good friend of my husband's and who subsequently paid him a handsome fee for campaign stories he wrote which helped him into elective office. This lawyer typifies the professional man whom Dr. Kellermann characterized as the "enabler," because he really did not understand alcoholism. He advised me that in every marriage a little rain must fall; sometimes the wife's poor housekeeping causes the friction; infidelity is far more disturbing than occasional drunkenness; I still have a home, adequate support, and might get none if we separated. So I gave up the idea and returned home more dispirited and hopeless than ever.

Inevitably, the alcoholism prog-

ressed to the point where days off to recover from bouts came closer together. The last six months of the drinking were spent as strangers under one roof, with scarcely a word spoken between us. My husband slept in the basement recreation room. The story—for the benefit of the children and which I'm sure they didn't swallow—was so that he would not disturb my sleep in the morning, as he left at six. In fact, it was the only way he could face a new day—by several drinks from a poorly concealed bottle as soon as he awoke.

I had forgotten how to laugh. I had become a martyr to my home—a perfectionist, withdrawn from any normal social activity, full of self-pity. I now know that my lack of insight into the problem did more to make our children feel insecure and unloved than anything he ever did. He was never violent, had a sense of humor that I lacked, and his children loved him, even though they could no longer respect the psychopathic liar he had become. But I wanted their love withheld as revenge for all the suffering he had caused us. So I played on their sympathies and tried my best to alienate them too. I also vented my many frustrations on them—being too permissive at times and unreasonably stern at others. On occasion, I must even have betrayed my unconscious resentment at having borne them, for without them, I would not have to endure another day of living with a drunk.

An accepted concept in A.A. circles is that the alcoholic will not seek treatment until he hits his bottom. However, I hit mine before he did, one day in late 1950 when he had been home for two weeks, a zombie in the playroom, going out only to replenish his daily quota of liquor, two quarts by then. He was a bloated, physical wreck, but the doctor's recent warning that he had less than a year to live unless he "moderated" his drinking had no effect. He seemed bent on slow suicide.

The time for concealment was past for me. I went next door to a neighbor to whom I had never breathed a word about our private little hell, and called his boss, the man who had tried to get him to join A.A. seven years earlier. I told him that Jack did not have the "grippe," that I was separating, and that if he felt he was still valuable to him as an employee, he could take over. He advised me to go home and say nothing about my call. An hour later, he returned it, asking to speak to Jack. He told him he thought he might need different medication, wouldn't it be wise to have the company doctor come over. Jack admitted that maybe he had been hitting it up a little too hard, and before that conversation ended, agreed to speak to two A.A.s whom the boss knew would come if called. A few days later, as Jack left with his two sponsors who escorted him to Towns Hospital in Manhattan, he warned me that the next time I saw him he'd be in a straightjacket and that sobriety was an impossibility for him. He knew he was headed for a mental institution for life. This he really believed, and I was almost convinced too. But after 10 days in the hospital, he remained sober seven years until his sudden death of a heart attack in 1958.

It is my firm conviction that had I not been driven by desperation into "creating a crisis," by the threefold technique I read about much later in Dr. Howard Clinebell's "Understanding and Counseling the Alcoholic through Religion and Psychology," Jack would have died years earlier of alcoholism. With his whole world collapsing simultaneously — job, family and health—the shock

propelled him to face reality.

For the first year of sobriety, our family tiptoed around the house and catered to his every whim. The thing which was most helpful at that stage was my playacting. Though very dubious that this miracle could last, I never displayed a moment's doubt or outward fear. Gradually the pretense became a reality, and I knew that A.A. therapy would keep my husband sober so long as he would accept the offered help.

However, the years of gradual withdrawal from any close circle of friends had taken their toll, and his sobriety alone was not enough to change me from a worried, fearful and deeply insecure individual, whose reactions during his active alcoholism may have had a more drastic effect on the personalities of our son and daughter than his actions. I was so lacking in confidence that it took great courage on my part to pick up the phone one day and call an absolute stranger, the mother of a school chum of my son's, who had told him that her father was also an A.A. member, and that the mother belonged to something called the "family group."

It was there that I learned I was expecting too much too soon, that for the wife and husband facing a sober marriage after many years of alcoholism, the nonalcoholic partner's expectations for happiness are often idealistic—and unrealistic. It would take time and real effort on my part to recognize and gradually repair the damage to my own personality, and those of the children. The Al-Anon program helped our marriage become what I had always dreamed it would—a maturing of two people into a happy give and take and restoration of mutual respect. I was no longer afraid to voice an opinion, for we could now discuss things reasonably. I was no longer fearful of enjoying life. It had numerous other rewards, the paramount one being a return to faith in a Higher Power, who will show us the way when we are in greatest need.

A year or so after joining the local group of Al-Anon, I heard of the need for volunteers at the Al-Anon Clearing House, where in January of 1954, I became the first paid staff member. In October of that year, the Clearing House was incorporated as a non-profit unit under the name Al-Anon Family Group Headquarters, Inc.

Since then, we have published several books and a varied assortment of pamphlets and leaflets to help those in, and not yet a part of our fellowship better understand the problems of the nonalcoholic, and an analysis of how a change in the attitudes of those close to the alcoholic can accelerate him to treatment.

Al-Anon and Alateen

Currently there are over 3,000 registered Al-Anon Groups in the U. S., Canada and 35 other countries and 400 Alateens, the junior segment of our society, where the children of an alcoholic learn to understand the complexities of this disease. It is easier for a child to accept the concept that his father is ill than that he does not love him. Alateen is filling a special need for the child who is reluctant to discuss his problems before trained counselors or in adult groups.

A similar hesitation in the nonalcoholic partner or other family member to accept sustained professional help is described by Dr. Margaret Bailey in her article, "The Al-Anon Family Groups as a Resource for Wives of Alcoholics," which appeared in the publication of the National Association of Social Workers.

Dr. Bailey states: "For social workers, the initial point of contact usually comes as a request from the wife of an alcoholic for help with problems created by his drinking. In general, social workers have found it difficult to deal with these clients, because of their defensiveness and tendency to discontinue treatment. As a result, professionals have often developed attitudes of pessimism and frustration, and the belief that these families are virtually untreatable.

"But in the Al-Anon atmosphere of strong support from their peers, the nonalcoholic partner may feel less need for defensive behavior. Though wives of alcoholics may not attend their first meeting explicitly seeking help for themselves, the setting very quickly influences them to shift in this direction.

"Professional help and Al-Anon affiliation need not, of course, be mutually exclusive or rivalrous, since the two methods contribute in different, but complementary ways to a common goal: recovery of the family from the destructive effects of active alcoholism."

In a comparative study of two groups of wives, Dr. Bailey found that those who belonged to Al-Anon or attended group therapy classes at the National Council on Alcoholism gained the knowledge that there are many things a wife can do to create a better life for herself and her children, even if her husband continues to drink. Her finding, that the Al-Anon membership of the wife is strongly related to the husband's attainment of sobriety, bears out our own experience. It is no coincidence that a great number of Al-Anons joined anywhere from a few weeks to several years before their spouses achieved sobriety either through A.A. or some other resource.

We can conclude that the major role of Al-Anon in lessening the impact of alcoholism on the family is to restore it to a semblance of normalcy by healing the nonalcoholic members, and creating a climate favorable for conditioning the alcoholic to face reality and accept treatment.

To demonstrate a second but very important role that Al-Anon has effectively played in ameliorating the impact of alcoholism on the family, I will read a letter typical of hundreds received in the course of a year at our office. It reached us just two weeks ago, and I cannot think of a better illustration of the value of Al-Anon in the years of adjustment to living with a sober alcoholic, than this of this member in England.

Phyllis wrote: "As for so many other wives of alcoholics, Al-Anon Family Groups have given me my backbone again to meet not only problems arising from alcoholism but day to day difficulties confronting every human being. It restored my sanity and stability—both very suspect after living with an alcoholic since 1940, and especially did it take me safely through what I and so many other wives I've met experienced as an even more tricky period—the early years following the giving up of drink and acceptance and participation in A.A. of our husbands.

"Right from our first introduction to A.A. in 1958, I've attended every possible A.A. 'Open Meeting' and gone Twelfth Stepping with Hugh (my husband) as I instinctively felt I needed the A.A. program just as much as he did. I got much from going to see the families concerned (if any) when he went on Twelfth Step calls soon after he'd found sobriety after his discharge from the Warlingham Park Alcoholic Unit in our neighboring county of Surry late in 1959. Yet this wasn't enough to keep me afloat and I was finding

myself emotionally and mentally akin to a dry drunk.

"I was an outpatient at the Chichester Psychiatric Hospital Hugh had first gone to, and by May 1962 I'd really reached my own rock bottom. By great fortune I met Al-Anon for the first time while attending the annual A.A. Convention that May at Bournemouth. The impact was terrific. I felt I'd been resurrected; hearing other wives tell their histories gave me so much to identify myself with, provided friends who understood and cared. To me, a desperately lonely isolated being, this seemed unbelievable but also of utmost importance. I found I was thinking, feeling and behaving like the average wife of an alcoholic instead of nursing the conviction that I was both peculiar 'round the head' and the only one of this odd and odious subhuman species.

I returned home so excited, I contacted wives I'd met at Open A.A. meetings during the previous years and transmitted my enthusiasm for the miracle of my newly found Al-Anon, and discovered at our own very first Al-Anon meeting we organized, that all these wives who had appeared so normal and content when we'd meet each other at the 'Open' A.A. meetings were under their skins in the same awful mess, seething with resentment, oozing self-pity, depressed, confused and unable to cope with the most simple of everyday problems, let alone themselves. Those with husbands who had been sober somewhile were like me, in the worst shape of all, disillusioned after the honeymoon period of sobriety had worn off. Their personal problems intensified rather than diminished, plus that horrible feeling of guilt that one ought to feel happy having a sober husband, but instead so depressed, one wondered what there was to go on living for! One wife who had appeared serene on the surface had contemplated suicide and admitted envying me for my apparent contentment. Yet underneath, I existed by daydreaming I might have the luck to be excused having to live much longer by contracting some incurable disease!

"Now we can laugh about those grim days—I got a small group going at Bognor Regis, Florrie started a group at Worthing and Carolina at Brighton, such was the benefit we all got from discovering Al-Anon and attending each other's meetings."

It is such letters as this—and witnessing the miraculous changes in the members of the groups I attend—that make me grateful to be associated with Al-Anon. To have even a small part in bringing hope to the hopeless is one of life's richest rewards.

IMPACT OF ALCOHOLISM

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gins to destroy his job, lose his health and become engaged in deviate behavior which the family can no longer conceal or absorb, few persons in our society including members of the helping professions will admit or recognize the existence of the illness. Once accepted all attention is generally focused on testing the alcoholic while there is almost universal abandonment of the support, therapy and aid necessary for the family if a genuine recovery from alcoholism is to be achieved.

If you will permit me to use the terminology of my own discipline, the church, I would describe Al-Anon as a group of persons who have learned to deal more adequately with their own pride and with some degree of humility are able to give to

their husbands the dignity to fail without harrassment or criticism, martyrdom or masochism. The synoptic message of the alcoholic is that he is God Almighty and no one will tell him what he has to do. Of course he is not God but he is completely right in preserving his volition against others who would attempt to play God, especially if wearing a skirt. The surrender of volition to other human beings is slavery. The surrender of volition to God is freedom, sanity and the genesis of self-love. If the family of the alcoholic aborts the consequences of the alcoholic's behavior by shielding and protecting him while suffering intensely from this course of action, love is replaced with fear and fear engenders compulsive action which destroys all semblance of marriage. In Al-Anon the wife learns the nature of her own illness, understanding of her own problem, acquires some ability in neutralizing her own destructive interaction with the alcoholic, and if needs be reach a degree of sanity and maturity which enables her to take a course of action which if pursued consistently may lead to recovery. It is not a blank check to purchase recovery for her husband but a means of acquiring help for self through a fellowship of understanding persons.

Family members may enter Al-Anon before the alcoholic considers treatment, at the time the alcoholic admits the need for help and initiates recovery, or in some instances the wife may enter Al-Anon after the husband is well on the way to recovery generally through active participation in A.A. Regardless of the point of entrance into the group, the role of Al-Anon is to meet the needs of members of families of alcoholics in their recovery process from alcoholism.

PSYCHIATRIC ASPECTS

CONTINUED FROM PAGE 14

out" social casework technique developed in order to maintain contact between program personnel and the patient and his family. It is this instance also that civil commitment process can perhaps be effective.

These combined efforts must work with the patient in living areas of employment and job-placement, financial support, family care, vocational counseling and job training, academic education, marital and family guidance, recreational and social interests, minority group relationships and acceptance of community obligations and responsibilities.

I believe that the drug-dependent person, and this includes the persons dependent upon alcohol, can be helped but only with an enormous expenditure of energy by the community resources of all professional and social groups. That punitive community, as experienced by the addicted person, that depriving environment which had made the addiction necessary, must now assume the role of the benevolent but firm communal parent. The community must become cognizant of the severe emotional sickness and the helplessness of the drug-dependent person. The community must recognize his total inability to provide help for himself with his problems of addiction and his incapacity to cope with the myriad of unpleasant realities of routine living even without the drug. The community dare not longer disregard its responsibility toward the care of its own problem of addiction, and, perhaps, its own responsibility in the creation of this problem. It is a financial burden, a costly one. But so is its cost in terms of self-degradation, family disintegration and social disorganization.

DIRECTORY OF OUTPATIENT FACILITIES

for

ALCOHOLICS AND/OR THEIR FAMILIES

Competent Help Is Available At The Local Level

Key to Facility and its Service

***Local Alcoholism Programs**

for
(Alcoholics and Their Families)

—Education
—Information
—Referral

†Mental Health Facilities

for
(Alcoholics and Their Families)

—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

—Outpatient Treatment Services

ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: 704-252-8748.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 919-228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m. - 4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon. - Fri., 9:00 a.m. - 4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro; Phone: 919-942-1089 or (if no answer) 919-942-1930.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: 704-375-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon. - Fri., 8:00 a.m. - 5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 316 E. Morehead St.; Phone: 704-334-2834.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00 - 5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; 919-682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m. - 12:00 noon. Thurs., 2:00 - 4:00 p.m.

**Wayne Council on Alcoholism;* H. B. Hulse, Executive Director; P. O. Box 1598. Phone: 919-735-7033.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 919-275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Executive Secretary; P. O. Box 2371; 915 Dickinson Ave.; Phone: 919-758-4321.

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: 919-438-3274 or 919-438-4702.

HENDERSONVILLE—

Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: 919-692-8118.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 919-883-2794.

LAURINBURG—

**Scotland County Citizens Council on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; P. O. Box 1229; Phone: 919-276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 919-637-5719.

**†*Psychiatric Social Service,* Craven County Hospital; Phone: 919-638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: 704-464-3400.

NORTH WILKESBORO

Wilkes County Council on Alcoholism; William S. Call, Executive Director; Old Elementary School Bldg.; Phone: 919-838-6046.

PINEHURST—

Sandhills Mental Health Clinic; Box 1098; Phone: 295-5661.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone: 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 919-633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: 919-692-6631.

WADESBORO—

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 704-694-2711.

WILMINGTON—

**Mental Health Center of New Hanover County;* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 919-736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

**†Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: 919-725-5359.

WISE—

**Warren County Program on Alcoholism;* Rev. W. G. Coleman, Director; Box 100; Phone: 919-257-4538.

EDUCATION AND INFORMATION SERVICES

INVENTORY—bi-monthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory,** go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

Consultant Service—for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

Education Division, N. C. Department of Mental Health
P. O. Box 9494
Raleigh, N. C. 27603

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